

## ABSTRACT

### SOCIAL WORK

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AN EXPLORATORY STUDY OF THE PSYCHOSOCIAL FACTORS THAT  
CONTRIBUTE TO RISKY SEXUAL BEHAVIOR AMONG AFRICAN AMERICAN  
COLLEGE AGED WOMEN

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This study examines whether or not HIV/AIDS education, socioeconomic status, and/or self-esteem affect the frequency with which African American women between the ages of 18 and 24 participate in risky sexual behavior. HIV is an acronym for the human immunodeficiency virus, which is the virus that leads to AIDS, the acquired immune deficiency syndrome. AIDS is one of the most deadly diseases affecting the world today and is the number one killer of African American women between the ages of 18 and 24. HIV/AIDS prevention education has been the major outreach tool used to combat the spread of this disease. However, prevention education does not seem to be impacting this population significantly, which leaves many searching for other answers for outreach.

The purpose of this study was to find out whether or not HIV/AIDS prevention education plays a major role in deterring this population from participating in risky sexual behavior or if self-esteem and socioeconomic status are more influential in this population's sexual decision making. A predominantly African American college

campus in Atlanta, Georgia provided a sample of 94 African American women between the ages of 18 and 24. Each participant completed a questionnaire regarding their HIV/AIDS prevention education level, their socioeconomic status, and their level of self-esteem. The data collected via the questionnaire were analyzed using descriptive, as well as, cross tabulation analysis. A focus group of ten participants was also convened to explore the responses on the questionnaires more in-depthly. While the findings did not show a significant relationship between socioeconomic status (SES), HIV/AIDS knowledge and risky sexual behavior, there was evidence of a relationship between self-esteem and risky sexual behavior. Implications for measuring SES and self-esteem in this population are discussed.

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COLLEGE AGED WOMEN

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I have ridden the shoulders of my **Mother** to arrive at my **Today**  
I hold her hands as I test the strength of my legs to climb into my **Tomorrow**

*-taken from an African Rites of Passage*

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## CHAPTER ONE

### INTRODUCTION

This chapter describes the purpose of this study, the background and statement of the problem, and the significance of the study. It includes an overview of the study's goals and closes with a brief description of the chapters that follow.

#### Purpose

This study was developed in an effort to gain further knowledge about the fastest growing group contracting HIV/AIDS, African American women between the ages of 18 and 24. Despite all of the efforts undertaken to educate this population about ways to protect themselves from contracting the disease, African American women are still continuing to participate in risky sexual behavior. The purpose of this study is to assess the sample population's risk factors as it relates to knowledge about HIV/AIDS, socioeconomic status, and self-esteem. In addition, this study seeks to determine if knowledge about HIV/AIDS is as great a factor of risky sexual behavior as socioeconomic status and self-esteem.

#### Background of the Problem

The largest growing group infected with HIV/AIDS is currently heterosexual women. Although African Americans make up only 12 percent of the population, they make up over 30 percent of the country's HIV/AIDS population (Center for Disease

Control, 1997). It is important that the reason for this disproportionate rate of infection is pinpointed in order to find more effective ways to counteract the epidemic at hand. Even though women make up the largest number of the growing AIDS population, they seem to be the group that receives the least amount of attention. The homosexual Caucasian male community has been the focal point of this society's "War on AIDS" and as a result the number of them contracting HIV/AIDS in this community has decreased significantly (Center for Disease Control, 1997). Through learning that HIV/AIDS is not a "gay Caucasian man's" disease, it is critical that African American women become a major target population for AIDS awareness and outreach. However, the prevention education that African American women are receiving is not deterring them from participating in risky sexual behavior that puts them at high risk for contracting HIV/AIDS. Research shows that all AIDS related prevention and intervention methods must be sensitive to the population's demographics, including age, gender, and education level (Grinstead, Peterson, Faigles, & Catania, 1997). This study seeks to show that the list for areas to break programs down surpasses demographics, such as gender and/or ethnic background, to include more individualized variables such as socioeconomic status and self-esteem.

#### Statement of the Problem

African American women are the only subgroup whose numbers are increasing, rather than decreasing, as it relates to HIV/AIDS diagnosis. Sixty percent of the heterosexual AIDS population today is comprised of women and a significant number of those women are African American (Center for Disease Control, 1997). In recent years, African American women have received more information about HIV/AIDS; however, it

has not helped to decrease the infection rates within this population. Many of these deaths are related to the fact that these women are economically disadvantaged and do not have the resources to “live with AIDS” (Center for Disease Control, 1997).

However, infection rates could be reduced if the professionals working directly with this population could understand why these women continue to engage in risky sexual behavior, in spite of their knowledge as it relates to the fatal consequences.

This study was developed in an effort to investigate what African American women know about HIV/AIDS transmission, as well as the consequences of infection. Furthermore, the study investigated the relationship between socioeconomic status and self-esteem as it relates to risky sexual behavior. Lastly, this study seeks to gain information about how often and why these women participate in risky sexual behavior despite the knowledge they possess about HIV/AIDS and how it is passed on from one human being to another.

### Significance of the Study

The findings of the literature show that there is a definite increase in the number of African American women both contracting and dying from HIV/AIDS (Center for Disease Control, 1997). Research has shown (Jemmott & Jemmott, 1992) that HIV/AIDS education and information alone does not affect decisions to participate in risky sexual behavior with any conclusive significance. Much of the literature, (Jemmott & Jemmott, 1992) of the research agrees that absence of HIV/AIDS knowledge is the primary reason why African American women are the fastest and largest growing population contracting HIV/AIDS. This study seeks to further solidify that theory and

present data showing other, more complex variables, weighing much heavier on the decision of these women to participate in risky sexual behavior than their HIV/AIDS.

This study will provide information regarding what factors contribute to the practice of risky sexual behavior among African American college age women. As there is still much HIV/AIDS research needed on this population, this study serves as a vehicle to move society in the direction of identifying the factors that contribute to risky sexual behavior as it relates to this group.

Chapter two of this study provides an overview of the existing empirical research on this topic, as well as the limitations. The third chapter describes, in depth, the methods used to conduct the study, including the setting, sample, measure, design, procedure, and data analysis. Chapter four consists of an analysis of the data, as well as a presentation of the findings using both graphs and tables. Chapter five discusses the findings as they relate to the literature and draws conclusions about the study's credibility. Finally, the sixth chapter discusses the implications of the study's findings as they relate to social work practice.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

AIDS has become a social problem that affects the entire world. There is no particular group that is safe or immune to it and as a result, human service providers have had to find more innovative and new ways to reach out to the populations deemed to be most at risk. However, in order to implement these new and innovative forms of outreach, much research must be performed in an effort to determine why it is that certain groups participate in acts that put them at greater risk for contracting HIV/AIDS. Unfortunately, these efforts have bypassed many communities, which has left many stones unturned and several variables overlooked. This section reviews the relevant empirical literature on the AIDS epidemic and risky sexual behavior in an effort to gain insight into what variables influence African American women to participate in such behavior.

#### The Epidemic of HIV/AIDS and Women

According to Stevens (1998), there has been an overall decline in the number of women contracting HIV/AIDS. However, the rate of HIV/AIDS among African American females is steadily on the rise. Furthermore, in recent years, it has become evident that this disease is progressing into even younger ages of the age spectrum. African American adolescents make up 36 percent of the entire AIDS population in the United States and a majority of that 36 percent is female (Stevens, 1998).

From 1985 to 1996 the number of reported AIDS cases among women escalated from 7 percent to 20 percent. Furthermore, HIV is now the third leading cause of death among women 25-44 years of age and the number one cause of death among African American women in the same age group (National Institutes of Health, 1996). According to Staples (2000), 54 percent of the new AIDS cases in the United States are African American females and 62 percent of all new HIV/AIDS cases in the United States are African American children, in part, because they are contracting the disease in utero (Staples, 2000). Many of the diseases that sometimes occur in uninfected women also occur more frequently in HIV infected women. Some of these include vaginal yeast infections, severe herpes simplex virus ulcerations, and pelvic inflammatory disease. Women who are experiencing these ailments should be tested regularly for HIV and often times are not (National Institutes of Health, 1996).

The number of African American women becoming infected with HIV is growing rapidly. Fears (1998) states that African American women are 8 times more likely to contract the virus than Caucasian women and they are 3 times more likely than Hispanic women. Studies also state that nearly half of all women infected with HIV are African American, even though African Americans make up only 13 percent of the U.S. population (Fears, 1998).

Between the years of 1985 and 1988, HIV infection quadrupled among women of color, most of whom reside in poorer inner-city areas. Of these women that are becoming infected, approximately 53 percent are African American and approximately 20 percent are Latin American (Chu, Buehler, & Berkelman, 1990). With the reality that HIV/AIDS is the leading cause of death among African American women ages 15 to 44

and among Latin American women ages 25 to 34, it is evident that these minority groups are being disproportionately affected by this disease. Many scholars and researchers predict that HIV/AIDS will soon become the leading cause of death among minority women of reproductive age (Chu, Buehler, & Berkelman, 1990).

In the state of Georgia, where this study was conducted, 82 percent of women with AIDS are African American. Georgia also has the eighth-highest number of reported AIDS cases and African Americans and Hispanics make up 50 percent of the people with "full blown AIDS" (Staples, 2000). Young adults, between the ages of 20 and 29, accounted for 20 percent of all AIDS cases reported in the state of Georgia during the years of 1981 and 1999 (DHR Office of Communications, 1999).

In the state of Georgia, during the early stages of the epidemic, most of the infected population were men. Between the years of 1984 to 1998, the proportion of female AIDS cases in the state of Georgia jumped from 4 percent to 19 percent. Specifically, more than 81 percent of women with AIDS in Georgia are African American (DHR Office of Communications, 1999). Many of these women contracted AIDS from having sexual intercourse with men who were either drug users, or men who had sex with other men. The majority of women contracting HIV in the state of Georgia were exposed through heterosexual contact. Further, approximately one in five children born to women with HIV/AIDS are born positive, which leads to the increasing number of children with HIV/AIDS among African Americans (DHR Office of Communications, 1999).

According to Reuters (1999), there is a significant amount of misdiagnosis when it comes to women and AIDS. Women are also rarely diagnosed with HIV early because



they do not fit into the stereotypical group identified as at risk (Reuters, 1999). The study also discussed the fact that women do not become active within the health care system until they have developed full blown AIDS, totally minimizing their chances of survival. Many are married, but have contracted the disease from their spouses and therefore are not being tested regularly for HIV. As evidenced by an ABC News study in 1999, seventy percent of HIV positive women sampled reported to have contracted the disease from their husband or committed partner (Reuters, 1999).

Although HIV can be transmitted through intravenous drug use, studies show that women in the United States, as well as in several other countries, become HIV positive as a result of sexual encounters (Roper, Peterson, & Curran, 1993). African American women increase their risk by having sexual intercourse with infected partners that are injection drug users or bisexuals. Studies show that the likelihood of an African American woman contracting HIV from a bisexual partner is four times greater than it is for a Caucasian woman in the same scenario (Selik, Castro, & Pappaioanou, 1988). This leads some researchers to conclude that prevention messages should recommend either abstinence or participating in sex with only those people that one knows well and knows is not HIV positive (Roper, et al., 1993).

### Risky Sexual Behavior

It has become apparent that a woman's sexual behavior in the past twelve months can be a viable predictor of the normal everyday sexual behaviors of the woman (Braithwaite, Stephens, Taylor, & Braithwaite, 1998). In a study of 1,593 African American college students, results showed considerable support, irrespective of race

and/or gender, that future sexual behavior can be determined by immediate past sexual behavior (Braithwaite et al., 1998).

African American females are eight times more likely to contract HIV than their Caucasian counterparts (Selik et al., 1988). Studies show that one explanation for this disproportionate relationship could be related to this group's preventive behavior, as well as their individual risk perceptions, as they relate to contracting the virus (Prochaska, Albrecht, Levy, Sugrue & Kim, 1990). It has been reported that many of these women do not perceive themselves as being at risk because they do not see any similarities between themselves and those persons that are in the stereotypical high risk group. Because many of these women do not participate in anal sex, or any of the other actions they perceive as the behaviors that put gay men at risk, it is hard for them to see themselves as falling into a high-risk category. Consequently, it is hard for them to see any reason to alter their sexual practices (Siegal & Gibson, 1988; Mays & Cochran, 1988).

One of the major factors contributing to African American women's continued participation in risky sexual behavior is their distrust of the United States healthcare and research efforts (Thomas & Quin, 1991). Research shows (Thomas & Quin, 1991) African Americans also attribute the existing statistics about African Americans and HIV/AIDS to society's efforts to portray them as reckless, criminals, prostitutes, and drug users. As a result, African Americans are extremely reluctant to acknowledge that there is a threat of AIDS permeating their communities. When efforts are made to provide preventive care information in black communities, the message is often missed because the messages are not delivered in a culturally sensitive manner. Furthermore, the black church, which is one of the most influential institutions within the black community, has

only recently begun to acknowledge HIV/AIDS as a problem in the African American community (Dalton, 1989; Hammonds, 1987).

Studies show that among many HIV tested populations there are a significant number of women that are participating in unprotected sex (Hines & Graves, 1998). The findings of such studies show that many of these women are more concerned about pregnancy than contracting HIV. Researchers conclude that it may be beneficial to merge HIV/AIDS prevention methods with pregnancy prevention methods (Hines & Graves, 1998).

Some researchers believe that risky sexual behavior occurs as a result of the African American woman's lack of "bedroom power." A study conducted by Weeks, Grier, Radda, & McKinnley, (1999), investigating risky sexual behavior, as it relates to African American women and their oppression in relationships, definitively explores the idea that much of the power that African American women give up in the bedroom is the result of numerous variables. Some of those variables include poverty, drug addiction, low self-image, and a need to give their African American male sexual partners the power in the bedroom because of the lack of power that they are afforded in society (Weeks et al., 1999). Other studies also discuss African American women being at risk for HIV/AIDS due to violence in their relationship. Many of these women indicate that they avoid suggesting the use of condoms with their sexual partners for fear that it may result in a violent situation. Furthermore, a significant number of women confess to have participated in sex because they fear a violent reaction from their partner if they refused (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998).

A 1991 study of face-to-face interviews on behaviors related to AIDS protection and contraception showed that African American women were more likely to use condoms than Hispanic and White women. The study concluded that increased condom usage among African American women must be a result of the HIV/AIDS protection messages being absorbed and put to use within this population (Hines et al., 1998). However, in 1997, African American women were still the largest growing group contracting HIV/ AIDS (Center for Disease Control, 1997).

### Socioeconomic Status and Risky Sexual Behavior

An overwhelming number of African American women that are infected with HIV/AIDS are poor, not well educated, and lack connection to community resources and healthcare (Cochran & Mays, 1993; Poppen & Reisen, 1994). In addition, another key factor that contributes to risky sexual behavior among African American women is that they are economically dependent on their sexual partners. This economic dependency may lead to a fear of jeopardizing the relationship and keeps these women from exercising their right to protect themselves (Peterson & Marin, 1988).

Research in the area of HIV and women in the United States indicates that risk occurs disproportionately among socioeconomically challenged women (Center for Disease Control, 1991). A study by Barker, Battle, Cummings, & Bancroft, (1998) shows that there is a direct correlation between socioeconomic status and risky sexual behavior. Barker's sample included 15 low-income African American women. The study included an intervention designed to infuse education that focused on HIV/AIDS prevention, as well as other life skills. After three months of educational training some of the mothers

expressed more trust in using condoms. The women that did not show any change after the educational training were said to have put short-term goals in front of long-term goals (Barker et al., 1998).

In a study examining factors associated with condom use in a community-based sample of 423, sexually active African American women, results showed that women in exclusive relationships evidenced lower intentions to use condoms. Fewer peers who engaged in preventative behaviors perceived themselves to have lower risk and had lower rates of condom use, higher education, and family income (St. Lawrence, Eldridge, Reitman, Little, Shelby, & Brasfield, 1998).

### Self-esteem and Risky Sexual Behavior

According to the literature, low sexual self-esteem is common among two types of women. The first type, includes women who perceive sexual contact as simply their responsibility in a relationship and receive virtually no pleasure from the sexual acts that they participate in. As a result, these women tend to not discuss their individual sexual needs with their partners, which includes their need to protect themselves. The second type of woman, includes those that perceive themselves as not having any control as it relates to their sexual relationships. These women do find pleasure in sexual contact, but, render all of the power and decision making to their dominant male sexual partner (Seal, Minichiello, & Omodei, 1997).

By testing personal and sexual characteristics, studies have shown that there is a direct relationship between sexual risk taking and sexual self-esteem (Seal, Minichiello, & Omodei, 1997). In this case, self-esteem is defined as a woman's ability to feel good

about herself or her perception of self-worth. Many existing STD and HIV prevention campaigns have neglected to include in their studies the idea that condom use among women is directly related to their perceived power. These studies also failed to recognize that women with poor self-esteem may have an extremely difficult time negotiating condom use with their more dominant male partner (Seal, Minichiello, & Omodei, 1997). Studies show that one reason that may contribute to the heterosexual female's lack of assertiveness in the bedroom may be the societal roles that they have been taught to adhere to over time. They have been taught to serve as care givers, to be subservient to the needs of others, and they may take these roles into their sexual relationships as well (Chodorow, 1978; Browne & Minicheillo, 1994).

The majority of studies that have focused on self-esteem and risky sexual behaviors have not found any significant relationship between sexual self-esteem and sexual risk taking (Tashakkori & Thompson, 1992). As a result, a definitive link between sexual self-esteem and risky sexual behavior has not yet been established and must be researched further.

### Limitations of the Literature

The majority of the studies available focused on AIDS as it relates to education and socioeconomic status. Most of the literature identified as useful for this study focused on a lack of education as a major contributor to risky sexual behavior. Socioeconomic status was also identified in many of the studies reviewed as a major contributor to sexual risk taking. However, there is a dearth of information available about AIDS as it relates to self-esteem, which implies that there is far more research

needed in that area (Seal, Minichiello, & Omodei, 1997). Another gap in the literature may be attributed to the misconception that African American women were not perceived as an "at risk group." In addition, there were virtually no historical views found to incorporate into this study, which may be attributed to the AIDS epidemic being perceived as a Caucasian male homosexual disease. Although the different studies presented a wide array of ideas, most of them were in agreement that African American women are in desperate need for more effective outreach in their communities, in an effort to decrease their participation in risky sexual behavior (Land, 1994).

### Proposed Study

The proposed study seeks to determine if there are, in fact, other variables not included in current HIV/AIDS education that may influence why African American college age women participate in risky sexual behaviors. For this study, three variables will be measured to assess risky sexual behavior: (1) self-esteem, (2) socioeconomic status, and (3) knowledge of HIV/AIDS information. The dependent variable is risky sexual behavior and the independent variables are socioeconomic status, self-esteem, and HIV/AIDS education.

### Hypothesis

The key hypothesis of this study was:

HO: HIV/AIDS knowledge, self-esteem, and socioeconomic status have no effect on an African American woman's decision to participate in risky sexual behavior.

HA: HIV/AIDS knowledge, self-esteem, and socioeconomic status have an effect on an African American woman's decision to participate in risky sexual behavior.

### Conceptual Framework

In order to begin exploring why African American women participate in risky sexual behavior, it is important that the Theory of Reasoned Action is incorporated. The Theory of Reasoned Action was developed by Ajzen and Fishbein (1980) and is a cognitive learning theory that is used to explain how a person makes certain decisions. It has been used to explain health behaviors such as cigarette and marijuana smoking (Ajzen & Fishbein, 1980). The theory is based on the premise that people are rational thinkers, who systematically weigh the options that they have and choose to, or not, to take certain risks (Ajzen & Fishbein, 1980). This theory suggests that a person's behavior is directly related to their intention to perform that behavior and that intention may be influenced by perceived consequences, social norms, attitudes, and self perceptions (Ajzen & Fishbein, 1980). For example, a woman's decision to participate in risky sexual behavior is influenced by what she considers as her perceived consequences, her social norms, her attitude, and her self-perceptions. Furthermore, it is important to note that the act of participating in risky sexual behavior is the observable result of the cognitive process that has taken place prior to any decision.

The Theory of Reasoned Action suggests that intentions are based on perceptions of social pressures and these intentions can be influenced by any of the groups that a person identifies with. Some of these groups may include parents, partners, church members, family, and friends. For example, a woman's decision to use a condom may be related to her perceptions of what her partner wants or feels about using a condom. The portion of the theory that is most integral to this study is the concept that, in order to



change behavior the model components that influence decision-making must be addressed. For the purposes of this study it was hypothesized that socioeconomic status, self-esteem, and HIV/AIDS knowledge are the model components that needed to be addressed in an effort to influence sexual behavior change.

This chapter presented an in-depth presentation of existing literature related to this study, as well as a discussion of the limitations of the literature. The variables discussed included socioeconomic status, self-esteem, and HIV/AIDS knowledge, as they relate to risky sexual behavior in African American women. The chapter also presented a discussion of this study's hypothesis and its' conceptual framework. The following chapter will provide an in depth discussion of the methods that took place during this study.

## CHAPTER THREE

### METHODOLOGY

This chapter describes, in specific detail, the methods that were used to conduct this study. This section includes a discussion of the setting, sample, measure, design, procedures and the data analysis used in the study. The chapter concludes with a summation of the methods.

#### Setting

A historically black university located in Atlanta, Georgia was chosen as the setting for this study. The setting for the post-test data collection portion of this study was a student organization meeting primarily populated by African American women. This site was selected because the HIV/AIDS knowledge of the group appeared to be varied and not specific to the site. The organizations were populated solely by African American women. This setting proved conducive to the study because there was no way to control the diversity of the population, and the study was hypothesized to be most beneficial if the population was as diverse as possible in its knowledge, self-esteem, and socioeconomic upbringing. The setting for the second mode of measurement, the focus group, was a residential apartment living room in an effort to present a comfortable environment. The focus group was scheduled for two hours (9:00 am-11:00 am) and breakfast was provided for all participants.

### Sample

The sample was selected from two separate student social organizations on the campus of Clark Atlanta University. One of the organizations included a greater number of women between the ages of 18 and 20, and the other organization included a greater number of women between the ages of 20 and 22. This was done for the sole purpose of reaching a wider range of women as it relates to age. There were approximately 94 women included in the sample. The women were asked, during the meeting, if they would be interested in participating in the study and those who agreed were given an informed consent form as well as a survey. They had approximately twenty minutes during their scheduled meeting time to complete the forms. Any woman attending the meeting was allowed to participate in the study if they desired, as long as they were African American, and were between the age group of 18 and 22. The focus group sample was a sub-sample of the post-test sample and was a randomly selected group, made up of ten African American women between the ages of 18 and 22. There may have been some threat to the validity of the focus group sample, due to the fact that the participants may have perceived the researcher as an influential figure on campus. This perception may have caused the participants to alter their comments, in an effort to give answers that they thought would be pleasing to the researcher. In order to minimize this threat, it was emphasized to all participants that they should be honest, that all of their comments were confidential, and that their comments would be used strictly for the purpose of this study.

### Measure

The data for this study was collected using two forms of measurement, a 25-item questionnaire and a focus group. The questionnaire consisted of a series of questions inquiring about the participant's socioeconomic background, self-esteem, and knowledge of HIV/AIDS. The questions contained a mixed response format with some brief response, multiple choice, as well as some Likert-type response questions, in order to assess the client's objective knowledge as it relates to the study. The survey was generated to glean some demographic information about the client as well. Many of the questions had either true or false answers, to allow the participant to move swiftly through the questionnaire, as well as, ensure that they had time to answer the more detailed questions completely. The instrument was pilot tested on five undergraduate students prior to the collection of the data and corrections were made to ensure its reliability. The construct validity of the measure may have been reduced because the variables, other than those specifically tested in this research, may have contributed to each participant's risky sexual behavior. However, this threat was minimized by the implementation of the focus group, which was a group interview where a series of six questions were asked, and each participant was given the opportunity to respond. The questions posed to the group were as follows:

1. What would you say are the reasons that you use/or don't use protection? (Condoms)
2. For those of you who are not sexually active, and have never been, what reasons would you give for your decision to abstain?
3. Where did you get the information that you now have about HIV/AIDS?
4. Do you think that self-esteem plays a large role in your sexual decisions?

5. Would you say that most of your peers use/ don't use protection? Why?
6. Overall give me your views on why you think that "we" represent the largest growing population contracting HIV?

The questions were all related to the participant's risky sexual behavior, or lack thereof, and they were asked to articulate their reasons for the choices that they have made in life as it relates to sex.

### Design

This exploratory study uses a non-experiment study design, more specifically the one-shot case study design. The design notation for this study is: X O where X is equal to the participant's risky sexual behavior, as it relates to HIV/AIDS knowledge, socioeconomic status, and their self-esteem. The O is equal to the measure. The literature states that this is a strong design when working with descriptive research questions; however, it can be weak in terms of internal validity (Cook & Campbell, 1979).

The internal validity of the research design may have been threatened by the fact that variables, other than those tested within the parameters of this study, could contribute to the participant's risky behavior as it relates to sexual intercourse. Some examples may include the participant's level of comfort with their partners, as well as their perception of risk. Therefore, there are moderate threats to the internal validity of the design.

However, effort was made to reduce this threat, by asking questions related to some of the variables during the focus group, so that they could be assessed along with the study's main variables.

### Procedure

The post-test only data collection for this research took approximately two days to complete. The two campus based organizations used to recruit the participants were contacted via each organization's presidents, and two separate data collection days were identified and confirmed. The questionnaire was drafted and then distributed at each organizational meeting during their scheduled afternoon meetings held on campus. Though all of the women in both of the meetings were asked to participate, some women exercised their right to decline. All of the data was collected only once at each organizations meeting. One limitation to collecting the data during the scheduled meeting time was that the members may have had their minds focused on the events to come in the meeting, which may have hampered their concentration. Furthermore, students may have rushed in an effort to move on with the meeting. Efforts were made to decrease this limitation, by making all members aware that the meeting would not convene until twenty minutes after the survey's start time, whether or not everyone had completed the survey. This was done to eliminate rushing the survey. The focus group was implemented after the post-test data was collected, in an effort to further research the participant's reasons for participating in risky sexual behavior. From the post-test sample, 10 of 19 participants contacted agreed to participate and were invited to meet for two hours over breakfast. The meeting took place in a residential facility on campus and was scheduled for two hours (9 am to 11 am). The seating was random and the setting was casual and relaxed. The facilitator went over the focus group agreement with the group and then breakfast was served. All six questions were asked and each participant responded to the questions that they felt most comfortable answering, until an informal

dialogue ensued and continued during the final thirty minutes of the meeting. Responses were written on a flip chart, so that the participants could view and confirm all information recorded. This process addresses data credibility and accuracy and also provided a feeling of security about the information being documented.

### Data Analysis

The study seeks to compare HIV/AIDS knowledge, socioeconomic status, and self-esteem, as it relates to one group's risky sexual behavior. Because differences were examined, the method of data analysis used was crosstab analysis. The average score of each variable was compared, as it relates to each participant's risky sexual behavior. The first hypothesis was that HIV/AIDS education had no major influence on risky sexual behavior. In order to test this assumption, the knowledge scores for each participant were measured against their individual risky sexual behavior. The same method was used to test the second and third hypotheses, which stated that the participant's socioeconomic status and self-esteem would be more of an impact on their risky sexual behavior, than their knowledge of HIV/AIDS. The data collected during the focus group was recorded and grouped by like answers and presented to provide insight into the data retrieved from the post-test. The participant's demographic information was analyzed using frequencies and descriptive statistics. All analysis was done using the SPSS-PC statistical package.

This chapter provided a discussion of the setting and sample and the reliability and validity threats that manifested as the study progressed. It also provided an in depth description of the tools of measurement, the type of design notation, procedures of the study, and the analysis of the data collected. The next chapter presents the study's

findings. For this research, tables and graphs were chosen to portray what was included in the frequency and descriptive analysis, as well as, the cross-tabulation analysis. From the collected information, the arithmetic mean was taken in order to make conclusions about the need for HIV/AIDS education, self-esteem boosters, and outreach, within the African American female population.



## CHAPTER FOUR

### RESULTS

This chapter presents the findings of this study in two sections. The first section includes the demographics of the post-test participants, as well as, the results of their questionnaires. The second section contains the demographics of the focus group and addresses the questions and answers discussed during the focus group.

#### Demographics

All 94 of the post-test participants were students at one of two historically black colleges. Ninety-one participants were African American and three chose "Other" as an option on the post-test questionnaire. As specified in the methodology, all of the participants were female, between the ages of 18 and 24. Specifically, 4 participants were 18 years old, 33 were 19 years old, 30 were 20 years old, 21 were 21 years old, and 1 was 23 years of age.

The sample did not include any members of the freshman class, however, there were 42 sophomores, 29 juniors, and 23 seniors. The participants were asked their sexual preference because the study specified that the sample would be heterosexual women, and among those who completed the questionnaires, 1 out of 95 was homosexual. This participant's information was included in the analysis of the post-test demographics information, but was not been included in any of the other analysis due to the restraints of the earlier specified sample. This information is included in Table 1.

Table 1

Post-test Demographics (n=95)

Variables	Participants
Age	
18-19	39.4%
20-22	59.5%
23-24	1.1%
Gender	
Female	100%
Ethnic Background	
African American	96.8%
Other	3.2%
Classification	
Freshman	0%
Sophomore	44.7%
Junior	30.9%
Senior	24.5%
Sexual Preference	
Heterosexual	98.9%
Homosexual	1.1%

## Variables

### Risky Sexual Behavior

Among the 94 participants whose information was analyzed in order to display these results, only 82 participants (12.8 %) answered the question regarding the frequency that they use protection during sexual intercourse. Of the 94 participants, 62.8 percent indicated that they always protect themselves, while some of the other participants (13.8%), answered that they use protection often, and 5.3 percent indicated that they rarely use protection and 3.2 percent answered that they never use protection during sexual intercourse. This information is displayed in Figure 1.

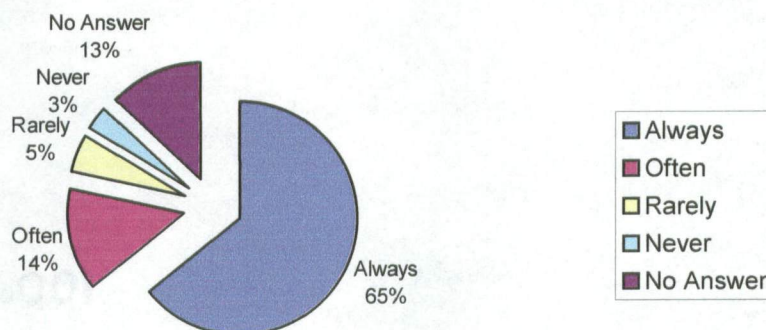


Figure 1. Frequency that Participants Use Condoms During Sex

Of the 94 participants, 37 indicated that they had no sexual partners in the past month, 52 indicated that they had between 1-2 sexual partners, 2 answered that they had between 3-4 sexual partners. Lastly, 3 participants indicated that they had more than 7 sexual partners within the last month. This information is displayed in Figure 2.



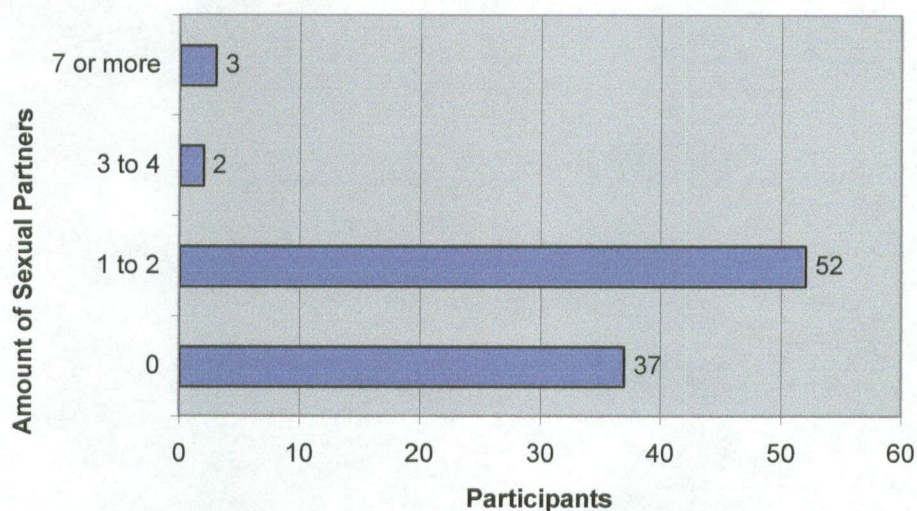


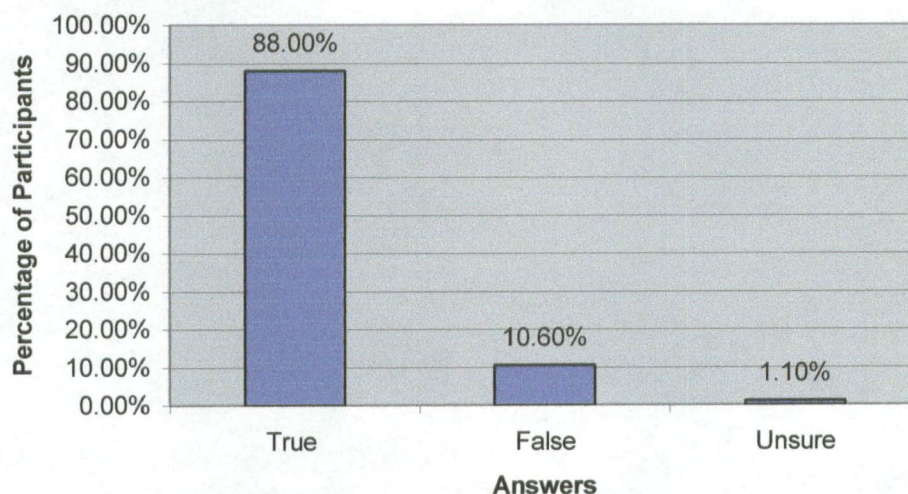
Figure 2. Participants Amount of Sexual Partners within the Past Month

On the questions about how many times the participants had sex per week, 38 participants indicated that they had no sexual encounters that they could track on a weekly basis, 41 participants answered that they had sex 1-2 times weekly, 9 indicated that they had sex 3-4 times per week, three participants indicated that they had sex 5-6 times, as well as 3, that indicated they had sexual intercourse 7 or more times weekly.

#### HIV/AIDS Knowledge

The majority of the participants answered the questions about HIV correctly (95.94 %). However, on the question inquiring the participant's knowledge about whether or not condoms reduce the risk of spreading HIV, a larger number than anticipated answered incorrectly (10.6 %). In total, 11 out of 94 participants either did not know, or were unsure, about the fact that condoms reduce the risk of contracting HIV via sexual intercourse (Figure 3).





**Figure 3.** Condoms Reduce the Risk of Getting the AIDS Virus

Four people (4.3 %) were either incorrect or unsure about whether or not a person could contract HIV by having sex just one time without a condom. There were very few people (1.1 %), who were unsure about whether or not heterosexual people could contract AIDS, or if birth control pills protected a woman from contracting AIDS during sexual intercourse. Although, when referring to information about a life threatening disease, a large number of participants either answered that they were “Unsure”, or answered incorrectly to this type of HIV knowledge based questions. An overwhelming number of the participants, (97.9 %), agreed that the knowledge that they possessed about HIV/AIDS empowered them to be more protective of their bodies.



### Socioeconomic Status

The participants involved in the study indicated that 60.6 percent of their mothers and 56.4 percent of their fathers had acquired a college education. Of the participants remaining 27.7 percent of their mothers and 22.3 percent of their fathers had completed a high school education; 6.4 percent of mothers and 10.6 percent of fathers had completed some form of trade school education; and 5.3 percent of the participant's mothers, along with 4.3 percent of their fathers, had only completed a grade school education. The parental education disparities among the group are displayed in Figure 4.

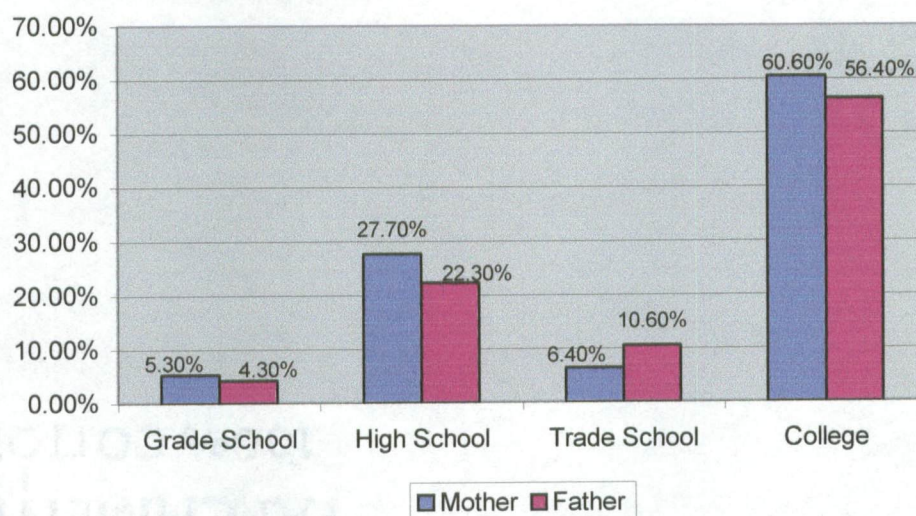


Figure 4. Participant's Socioeconomic Background Disparities

Most of the participants indicated that their parents were married (45.7%) and that their household income, while they were living at home, was \$51,000 or above (36.2%). Among the other financial brackets listed as appropriate answers, the number of participants who chose them was fairly equal. The answers were listed in \$9,000 increments and each increment obtained approximately 13 percent of the participant's

responses (Figure 5). Of the 94 participants, 77.7 percent reported receiving some state or federal aid to fund their college education. The rest of the participants reported that they did not receive aid (21.3%), or were unsure (1.1%), about whether they were receiving aid to attend school.

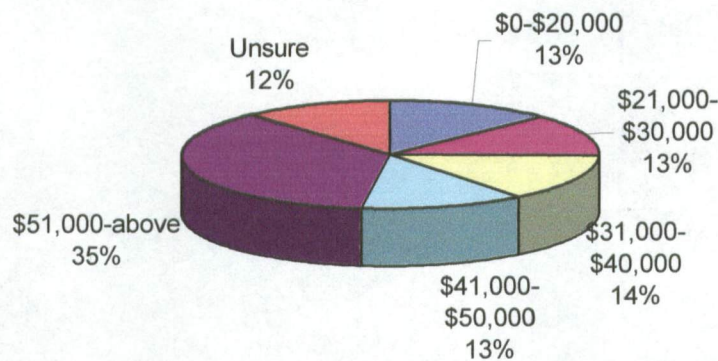


Figure 5. Household Income Disparities

Approximately 93 percent of the participants answered positively to the questions about self-esteem; meaning, the participants' answers reflected that they had high self-esteem as it related to perceptions of themselves. However, on the answers pertaining to whether the participants were satisfied with themselves as a whole, the level of positive answers was slightly spread out. Sixty-seven percent of the participants "Strongly Agreed" that they were satisfied with themselves, and 27.7 percent "Agreed", without strong feeling, that they had achieved some level of self-satisfaction.



A large number of the participants (42.6%) “Strongly Agreed” that they did feel powerful in their sexual relationships, as opposed to 6.4% of the participants who indicated that they did not feel powerful as it relates to their sexual partners (Figure 6). The remaining participants indicated that they “Agreed” (34%) to feeling powerful in their sexual relationships and none of the participants selected the option for “Strongly Disagree”, indicating that they felt no power in their sexual relationships. Of the 94 participants, only 84 replied to the question inquiring about how comfortable they felt with discussing their sexual preferences and 69.1 percent indicated that they did feel very comfortable discussing their preferences with their partners; 14.9 percent selected the “Agree” option, indicating that they felt some level of comfort discussing their sexual preferences with their partners (Figure 7).

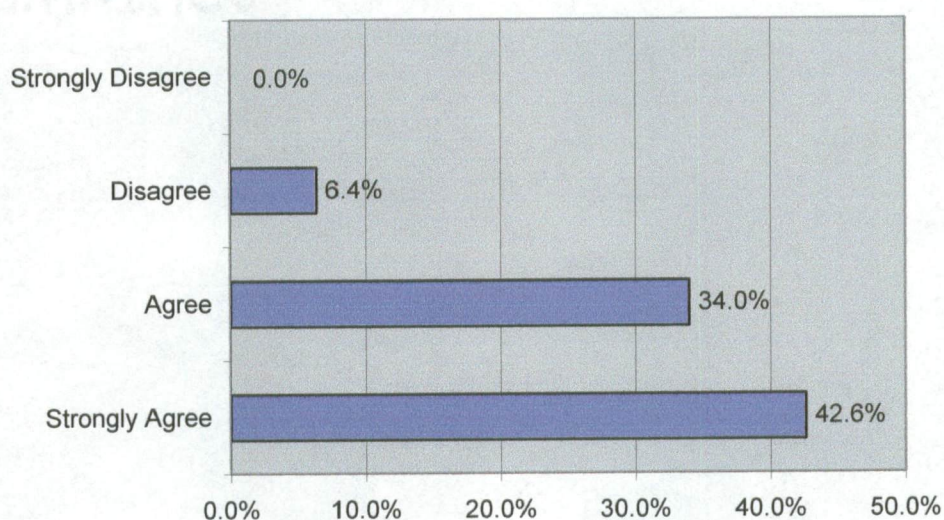


Figure 6. I Feel Powerful in my Sexual Relationships

Preliminary analysis using cross tabulations showed that there was no significant relationship between the participants' to risky sexual behavior and their socioeconomic



status, self-esteem, and HIV/AIDS knowledge. As a result of this probe, a focus group was conducted to explore their responses more in-depthly and the results of this group's meeting are presented in the following section.

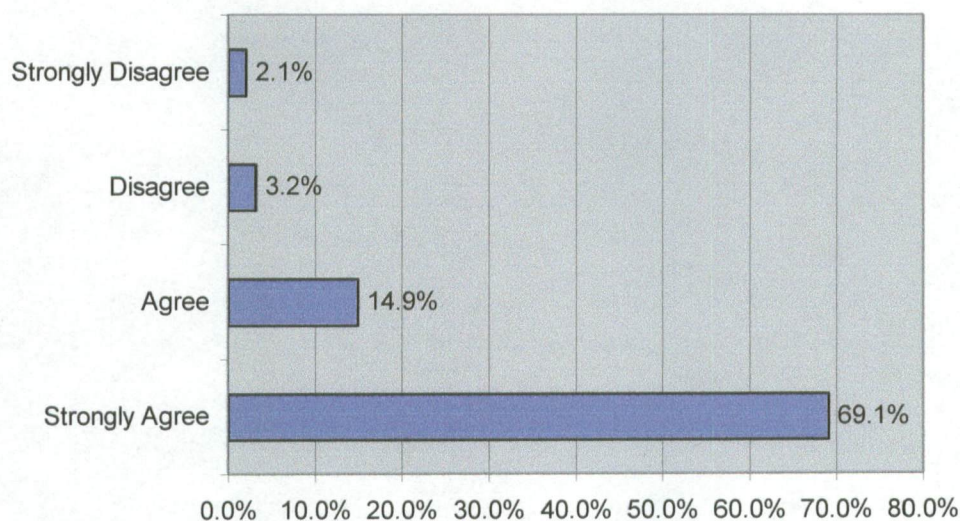


Figure 7. I Feel Comfortable Discussing my Sexual Preferences with my Partner

#### Focus Group Results: Demographics

All (10) of the focus group participants were randomly chosen from the post-test sample. Of the 10 young ladies chosen, 1 was a freshman, 3 of them were sophomores, there were 3 juniors, and 3 seniors. The age groups of the participants varied to include 18 year olds (2), 19 year olds (3), 20 year olds (1), 21 years olds (2), and 22 year olds (2). This information is presented in Table 2.

Qualitative responses were sorted and grouped according to similarity. These groups were based on the emergent themes in the data (Weller & Romney, 1988). A

Table 2

Focus Groups Demographics (n=10)

Variables	Participants
Age	
18-19	50%
20-22	50%
Gender	
Female	100%
Ethnic Background	
African American	100%
Classification	
Freshman	10%
Sophomore	30%
Junior	30%
Senior	30%

series of six questions were addressed during the focus group and the responses of the group were as follows:

1. What would you say are the reasons that you use/or don't use protection? (Condoms)

Of the ten participants, participants all stated that they were sexually active, or had been at one time. Five of those eight participants admitted that they have participated

in sexual intercourse without a condom. Of the five that spoke of participating in sexual activity without a condom, none of them could clearly give a reason for their decision. Some attributed their decision to being “caught in the moment”, which they explained meant that they did not want to interrupt the progression from foreplay to intercourse for fear that they may lose the “mood.” Others explained that they were in committed relationships and “trusted” that their partners were not having sex with anyone else. One of the participants explained that she did feel apprehensive about using condoms, but her partner expressed a dislike about the feelings that using a condom gave him. As a result, she decided not to use them. Overall, among the participants who had participated in sexual intercourse, there seemed to be a general sense of confusion about why they did not use protection.

Unlike the five participants who participated in sexual intercourse without a condom, the three sexually active participants who used condoms appeared clear on the reasons that lead to their decision. They generally agreed that “sex kills” and that they did not feel comfortable enough with anyone to put their lives in that person’s hands. One of the three participants emphasized that she had at one time contracted gonorrhea from a male partner whom she thought she was in a monogamous relationship with. As a result, she realized that it was her responsibility to protect her own body.

2. For those of you who are not sexually active and have never been, what reasons would you give for your decision to abstain?

There were two participants in the group that stated that they were virgins, meaning that they had never participated in sexual intercourse. Both participants were products of two married, college educated couples and agreed that their parent’s

influence has helped to shape their decision to abstain. One of the two participants stated that she was Catholic and that her religious beliefs guided her to the decision not to have sex before marriage. Both participants proclaimed themselves to be extremely positive about who they are and exhibited high self-esteem as it related to being secure in their decision making. They stated that they both had some knowledge of HIV/AIDS and other sexually transmitted diseases and that knowledge has only strengthened their decision to remain abstinent.

### 3. Where did you get the information that you now have about HIV/AIDS?

Nine of the participants stated that the majority of their HIV/AIDS education was obtained since they began their matriculation through college. They also stated that the information received has not come while in the classroom, but through other vehicles, such as seminars, health fairs, and the media. Two of the eight made reference to the fact that AIDS is a far more public issue now than it was when they were living at home and they indicated that they were not sure if that has contributed to "this sudden rush for all of the campus organizations to begin education on the subject of "AIDS."

There was one participant who indicated that her knowledge about HIV/AIDS was extensive and that her parents had educated her on the subject. She shared with the group that this education came as a result of her older sister's untimely passing due to complications of an HIV related illness. Although the situation did become emotional for this participant, she did tell the facilitator in front of the group that this had been her reason for agreeing to participate in the group because she was not only interested in the findings of the study; but, also interested in being a part of any effort to find out why her peers knowing all they know about HIV/AIDS, would have sex without condoms.

4. Do you think that self-esteem plays a large role in your sexual decisions?

Only four of the participants chose to comment on this question. Of those four, two stated that they both cared a lot about who they were and about the bright future that they both had ahead and both of them spoke of how being secure in themselves has a lot to do with why they don't allow anyone to talk them out of protecting themselves. One of the two participants said, "Nobody loves me like me. So, I know nobody is going to look out for me like me."

The other two participants who responded to this question stated that they did not perceive themselves to be as confident as the participants who responded previously. One of them said that it was her lack of confidence in herself that contributed to why she had decided to have sex without a condom, because she did not want to disappoint her boyfriend. She talked about a situation where her boyfriend told her that the reason she wanted to use condoms must have been because she was cheating on him; and in an effort to reassure him she decided not to protect herself.

5. Would you say that most of your peers use/ don't use protection?

Overall, the group agreed that most of their peers use protection during sexual intercourse, but emphasized that they do not use protection on a regular basis. They said that the decision to use protection usually varied from partner to partner, based on the relationship that their peers had with their partners.

6. Overall give me your views on why you think that "we" represent the largest growing population contracting HIV?

The participants' responses to this question varied tremendously, which lead to a lengthy discussion. Three of the participants discussed the fact that we are at a very

trusting age and stated that they have spent much of their time in college searching for acceptance. One participant said, "Being accepted by a guy and truly believing that he loves you is a wonderful feeling, one that many of us come to college seeking, so believing that this guy could sleep with someone else is unheard of." Another participant replied, " Sometimes we have sex without condoms even when we don't think the guy loves us, I have done it before because I didn't want the guy to think that I was questioning his commitment because we weren't in a relationship yet." One of the participants also interjected that " Some men think that when you ask them to wear a condom it is because you are having sex with a lot of people and they get apprehensive about it."

There was also some discussion among other group members concerning the fact that many of us do not acknowledge the fact that black men can be bisexual and so we tend to not acknowledge homosexuality in our communities. By not acknowledging it, we tend not to identify ourselves as being at risk for HIV/AIDS. Lastly, the group conceded that understanding why we put ourselves at risk was almost impossible, because they believe that the reasons for those kind of decisions varied greatly from one woman to another.

The purpose of this study was to discern why African American college aged women continue to participate in risky sexual behavior, despite the knowledge that they possess about HIV/AIDS. It was expected that self-esteem and socioeconomic status would prove to be integrally related to risky sexual behavior among this population. Though the results showed no significant correlation between risky sexual behavior and socioeconomic status, the results from the focus group did show that there maybe a

relationship between risky sexual behavior and self-esteem. Furthermore, the results showed that there was no significant difference, as it relates to the participants HIV/AIDS knowledge, and their risky behavior, which proves that there must be variables other than education that contribute to this group's decision to participate in risky sexual behavior.

This chapter presented an in depth discussion of the analyzed results of both the post-test data and the focus group data collected in this study. Although there were no significant relationships presented in the analysis of the post-test data, the discussion of the participants during the focus group did show that there may be some relationship between the self-esteem and the risky sexual behavior of this group. The results also showed that, despite the knowledge that these women possess as it relates to HIV/AIDS, some of them still chose to participate in risky sexual behavior. In the following chapter the findings of this study will be discussed as it relates to the literature discussed in Chapter 2, the conceptual framework, and this study's hypothesis.

## CHAPTER FIVE

### CONCLUSIONS

This chapter presents the reader with a discussion of the findings of this study and how those findings compared to studies previously done in the area. It also provides the reader with a discussion of further research that may be needed in the area based on the results of this study. The findings of this study showed that HIV/AIDS knowledge and socioeconomic status had no significant effect on the participants decision to participate in risky sexual behavior, which supported the hypothesis only in part. It stated that HIV/AIDS knowledge would not be a major factor in sexual risk taking, however, it stated that socioeconomic status would prove to be a major factor in risky sexual behavior and the results of this study showed otherwise.

One of the variables tested in this study was self-esteem. The literature reviewed in preparation for this study, suggested that further research was needed in the area of self-esteem to establish if there was a link between self-esteem and risky sexual behavior (Tashakkori & Thompson, 1992). The findings of both the post-test and focus group portions of this study supported the literature in suggesting that there is a need for further investigation. The results of the post-test showed no significant relationship between self-esteem and risky sexual behavior. Despite any of the answers given by the participants about their risky sexual behavior, the majority of the participants exhibited a high level of self-esteem (67%) as it related to their self satisfaction and a significant number (42.6%)



indicated that they felt strongly about their confidence in their power as it related to their sexual relationships. This suggested that the participants who have chosen to participate in risky sexual behavior have made that decision without low self-esteem as a factor. Furthermore, from the perspective of the theory of reasoned action, the post-test results of this study suggest that self-esteem has virtually no affect, or cannot yet be linked to the intentions of the participants to participate in risky sexual behavior.

Although the post-test responses suggested that there was no relationship between self-esteem and risky sexual behavior, the focus group responses suggested that a relationship could be inferred and further qualitative research may be needed in the area. Some of the participants indicated that they did feel less powerful in their sexual relationships than in other segments of their life, which supported previous studies. Weeks et al. (1999) discussed the African American woman's lack of "bedroom power." They also indicated that they did not really feel confident in themselves in several aspects of their lives. Although the focus group suggested that there may be a link between self-esteem and sexual risk taking, the results were not definitive in tying the two together. This may have occurred because, unlike previous studies that measured sexual self-esteem by measuring characteristics (Seal, Minichiello, & Omodei, 1997), this study relied on the participant to give their perception of their self-esteem, which may have left room for error.

These results raised several new questions that must be further researched. One being, what is a young African American woman's view of sexual self-esteem and what actions does she view as powerful as it relates to her sexual encounters? It became evident throughout this study that self-esteem is relative and subject to perception. So, it

may become necessary, when conducting further research in this area, that self-esteem be measured by observable behavior rather than personal perception.

Both HIV/AIDS knowledge and socioeconomic status showed no significant relationship to the participants decision to participate in risky sexual behavior. The majority (95.94%) of the participants proved to be knowledgeable about contracting HIV/AIDS and although there were differences between the participants socioeconomic backgrounds, the cross tabulations run did not show any relationship between the participant's socioeconomic status and their participation in risky sexual behavior. One of the reasons that there was no linkage made between sexual risk taking and socioeconomic status, could be because there may have been a leveling off status, once the participants began matriculating through their respective colleges or universities. It is important to recognize that much of socioeconomic status has to do with class and although the participants may have descended from different socioeconomic backgrounds, they now dwell in a place where their individual classes have merged.

Many of the previous studies measuring socioeconomic status and sexual risk taking (Cochran & Mays, 1993; Poppen & Reisen, 1994), used samples that consisted of women who were poor; and living in that state at the time of the study. One of the major differences, between this and previous studies, is that the sample used in this study cannot be categorized as poor. They have reached a stage of leveling off and this may have played a major role in why their responses did not show a significant correlation between sexual risk taking and socioeconomic status.

The results of the focus group did show that there may be a connection between self-esteem and risky sexual behavior, which supports the hypothesis in its statement that

self-esteem levels would play a major role in the decision to participate in risky sexual behavior. Although only supported in part, the rationale for the hypothesis was the climbing rate of heterosexual African American women contracting HIV/AIDS, despite the abundance of knowledge available to them about sexually transmitted diseases and ways to protect themselves from contracting them.

The focus of this study was to attempt to explain why, despite all of the information available about HIV/AIDS African American women continue to participate in risky sexual behavior. Much of the literature supports the fact that African American women are the fastest growing group contracting HIV/AIDS (National Institutes of Health, 1996; Center for Disease Control, 1997) and although there have been several initiatives made in an effort to reduce this steady climb, in a sense they have failed. With the rate of contraction among this population steadily on the rise (Center for Disease Control, 1997), it has become evident that further research must be done in the area so that the rate of contraction can be slowed and eventually nonexistent.

The Theory of Reasoned Action suggests that social factors play a large role in a person's intentions (Ajzen & Fishbein, 1980). It also suggests that actions are the manifestations of those intentions. If this theory is true, than although the results of this study do not support it, there must be room for further study in the area. This further study should include a study of the participants' intentions, rather than their actions, if such a study is possible.

### Limitations of the Study

In retrospect, things initially viewed as assets to this study at the outset have proven to be limitations in its conclusion. For example, when identifying the group to sample for this study, choosing a group of women that were knowledgeable, had a moderate socioeconomic background, and who were relatively new to sexual experiences seemed like an ideal choice. The fact that a group, moving so positively into the future, would participate in high risk sexual behavior set a tone for further research. However, choosing such a population may have minimized the opportunity to measure socioeconomic status as a variable, due to the virtual nonexistent class structure at the college level. It may be possible that socioeconomic status may play a larger role in non-college students, or professionals, who have already completed college; but, to students currently matriculating, it does not seem to play a major part in their sexual risk taking.

One of the limitations of this study was that there was no way of discerning how truthful the participants were in their answers. This may have skewed the results, if the participants were reluctant to choose what they perceived as negative answers. For example, they may have been reluctant to suggest that they were not powerful in their sexual relationships, or that even as college students, matriculating through an academic institution, they felt like failures. Attempts were made to minimize this limitation by using a confidential measurement tool, however; this may have not been enough to ensure truthful answers.

Some of the other limitations to this study include, an inability of the study to effectively measure self-esteem without the inclusion of the participants' perception. The inclusion of perception poses as a limitation because perceptions vary. For example, one

participant may view power in sexual relationships differently than another, which may cause them to respond differently to a question regarding their perceived sexual power. Finally, the results of the qualitative portion of the study (the focus group meeting) in the end, proved to be most effective in revealing any relationship that the variables may have had to risky sexual behaviors. So, it is imperative that more qualitative research be done in this area, in order to pinpoint the links of social factors to the intentions that African American women have about participating in risky sexual behavior.

The results of this study present a wide array of ideas for further research , as well as, display many methodological factors that must be included when conducting studies similar to this one. For example, when utilizing college students as a study's sample, there must be some understanding of the fact that socioeconomic status may not be easily measured. Also, future studies may consider measuring self-esteem from an observation standpoint, rather than asking for the participants' perceptions. Doing so may create a more concrete view as to whether self-esteem plays a major role in a college aged African American woman's decision to participate in risky sexual behavior.

This chapter presented a discussion of the findings of this study, as it relates to research previously done in the area. It also presented a discussion of the limitations of this study, as well as, a discussion of the results of this study as they relate to the Theory of Reasoned Action. The following and final chapter will provide a discussion of the implications for social work that this, and other similar studies have, as well as suggestions for further research.

## CHAPTER SIX

### IMPLICATIONS FOR SOCIAL WORK PRACTICE

In this chapter, a detailed discussion regarding the implications of this study to the field of social work, as it relates to the roles and responsibilities of practitioners, is provided. There is also some discussion of related areas that need further investigation.

The purpose of this study was to discern whether HIV/AIDS knowledge, socioeconomic status, and self-esteem play a role in the decision of a college age African American woman to participate in risky sexual behavior. Although the results of the study were not definitive, they presented an excellent platform for further research in the area and suggested that social work practitioners and others working in helping professions may want to explore other avenues in HIV/AIDS health prevention.

The results of this study impact the profession of social work at several different levels. It provides social work practitioners with more information regarding where outreach in the African-American female community is lacking, as well as, beneficial information to social workers about how to proceed further in their efforts to work towards the decline of the spread of HIV/AIDS in the African American female community. The information gained from this study also provides social work evaluators with a basis to work from when evaluating the effectiveness of social work outreach programs, as it relates to the areas of focus. Furthermore, the results may also better equip social workers in the counseling of populations similar to the one sampled in this research study.

Social workers, working along side university officials and professors, can use the information gained from this study to implement HIV/AIDS initiatives in Historically Black Colleges and Universities all over the country. This female population is within the age group that the Center for Disease Control identified as the fastest growing group contracting HIV/AIDS. Although they are matriculating through a secondary education institution, African American female collegiate are in need of outreach efforts on campus. It is also important to note that one of the roles of the social worker is that of an educator. So, it is within the parameters of the social work profession to serve as a visionary as it relates to new education initiatives that can be implemented at the college level, in hopes that these initiatives may include a focus on self-esteem and sexual empowerment.

The social work profession's emphasis on empowering the client can be extremely useful when working with a population similar to the one used in this study. The results of the focus group did show that there was a slight relationship between self-esteem and risky sexual behavior and some empowerment interventions implemented within this population could prove to be useful in the effort to decrease their risky sexual behavior. The implementation of such programs may also assist in empowering this population to advocate for themselves as equal participants in their sexual relationships.

It is important that social workers use information, such as the results of this study and studies similar to this one, to create both culturally sensitive and gender sensitive interventions, in hopes to reach the enormously diverse population of African American collegiate women. Because social workers and their ideas greatly influence policy, they have a significant advantage in making sure that new policies include an effort to be sensitive to all high-risk populations. Social workers may be better suited to work toward

the planning of creating self-esteem programs, in an effort to reduce risky sexual, behavior than any other professionals working to prevent the spread of HIV/AIDS. Their knowledge of the importance of psychosocial factors on decision making, as well as, their knowledge of the fact that one must change thought in order to change behavior, could prove to be invaluable in the planning of new HIV/AIDS prevention programs. Social work practitioners must be committed to advocating for programs better suited for African American females, in an effort to decrease their contraction of HIV/AIDS.

There must be continued research in the area of HIV/AIDS prevention and strides must be made in understanding the reasons that high-risk groups continue to participate in risky sexual behavior. As a result of this study, many suggestions can be made to those interested in researching the topic further. For example, the results of this study suggested that close attention be given to defining socioeconomic status when choosing a sample. Class or socioeconomic status can be subjective in the sense that class can be arbitrarily designated or self identified. It can also change from one time to another based on one's place in life (Pryor, 1981). There must be further research done in this area, in an effort to create more effective HIV prevention programs, and more importantly, to put a stop to the rapid spread of this disease among African American women.

HIV/AIDS has become a social issue, not only here in the United States, but, around the world. Until the extermination of the disease, social workers must continue to be committed to working towards efforts that support a decrease in risky sexual behavior among all populations, but specifically high-risk populations. It is important that social workers continue to contribute to the area of research on HIV/AIDS from a psychosocial



perspective, so that studies exist to aid program planners in their efforts to create new and innovative initiatives. Social workers must continue to be vital components in this society's "war on AIDS".

## APPENDIX A: QUESTIONNAIRE

*The purpose of this questionnaire is to obtain information about one's sexual risk factors.*

**Directions:** Please fill out the following questionnaire to the best of your ability. **Do not sign your name to the questionnaire**

1. How old are you: \_\_\_\_\_
2. What is your gender: (circle one) Male (1) Female (2)
3. Would you consider yourself: (circle one)  
African American (1), Caucasian (2), Latino (3), or Other (4)
4. What is your classification: (circle one)  
Freshman (1), Sophomore (2), Junior (3), Senior (4)
5. How would you describe your sexual preference: (circle one)  
Heterosexual (1), Homosexual (2), Other (3)
6. How many sexual partners have you had in the past month (circle one)  
0 (0), 1-2 (1), 3-4 (2), 5-6 (3), more than 7 (4)
7. How many times do you engage in sexual intercourse per week: (circle one)  
0 times (0), 1-2 times (1), 3-4 times (2), 5-6 times (3), more than 7 times (4)
8. Would you say you use protection during sex: (circle one)  
Always (1), Often (2), Rarely (3), or Never (4)
9. Only people who look sick can spread the AIDS virus. (circle one)  
True (1), False (2), Unsure (3)

## APPENDIX A continued

10. Condoms reduce the risk of getting the AIDS virus. (Circle one)

True (1), False (2), Unsure (3)

11. A person can get the AIDS virus even if he or she has sexual intercourse just one time without a condom. (circle one)

True (1), False (2), Unsure (3)

12. Only people who have sexual intercourse with gay (homosexual) people get AIDS.

(circle one)

True (1), False (2), Unsure (3)

13. Birth control pills protect a woman from getting the AIDS virus. (circle one)

true (1), false (2), unsure (3)

14. Do you think that the knowledge that you have empowers you to be more protective of your body? (circle one)

Yes (1), No (2), Unsure (3)

15. What is your parent's education levels:

Mother: (circle one) Grade school (1), High school (2), Trade school (3), College (4)

Father: (circle one) Grade school (1), High school (2), Trade school (3), College (4)

16. Are your parents: (circle one)

married (1), divorced (2), separated (3), never been married (4)

17. While living at home would you say that your household income was: (circle one)

\$20,000 or below (1), \$21,000-\$30,000 (2), \$31,000-\$40,000 (3), \$41,000-\$50,000 (4),

\$51,000 or above (5), Unsure (6).

## APPENDIX A continued

18. Do you receive federal or state funds to aid in your college expenses: (circle one)

Yes (1), No (2)

19. I feel that I am a person of worth, at least on an equal basis with others.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

20. I feel that I have a number of good qualities.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

21. I feel that I am a failure.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

22. I do not have much to be proud of.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

23. I take a positive attitude toward myself.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

24. On a whole I am satisfied with myself.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

25. I feel powerful in all of my sexual relationships.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

26. I feel comfortable with discussing my sexual preferences with all of my partners.

Strongly Agree (1), Agree (2), Disagree (3), Strongly disagree (4)

**Thank You For Your Time**

## APPENDIX B: INFORMED CONSENT FORM

The objective of this study is to gain insight into the knowledge that most African American college aged women have about HIV/AIDS as a whole, as well as, gain insight into the frequency that these women participate in risky sexual behavior. The results will be used to further assess whether or not HIV/AIDS outreach/education is effective among this population. This research serves as part of the requirements needed to obtain a Masters degree in Social Work for Clark Atlanta University located in Atlanta, Georgia.

The study will be anonymous and participants will be asked to answer all questions. The questionnaire will make inquiries about such things as the participant's ethnic background, age, socioeconomic status, self-esteem level, and the participant's knowledge about HIV/AIDS. Participation in the study is totally voluntary; those who elect to take part in the study will remain totally anonymous and the information will be reviewed and summarized without prejudice.

Please understand that there are no foreseeable risks involved in this study. If at any time you feel uncomfortable with a question or any of the subject matter, feel free to speak with the facilitator.

If you agree to voluntarily take part in this study please sign and date two copies of this document. Turn one in and keep one for your records.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX C: SITE APPROVAL LETTER

We, \_\_\_\_\_, give Aisha Tucker-Stephenson permission to conduct research at our agency for the sole purpose of completing the degree requirements of Master's of Social Work at Clark Atlanta University. It has been explained by the researcher that the participants will not be at risk and will not suffer from any stresses or discomforts. The participants are volunteers and may remove their data at any point to the extent that it can be identified.

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Researcher

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Site Liaison

## APPENDIX D: ITEM-LEVEL DESCRIPTIVE COEFFICIENTS SUMMARY TABLE

Question	N	Mean	Std. Deviation
1. How old are you?	94	19.9255	1.0290
2. What is your gender?	94	2.0000	.0000
3. Would you consider yourself:	94	1.0957	.5301
4. What is your classification?	94	2.7979	.8109
5. How would you describe your sexual preference?	94	1.0106	.1031
6. How many sexual partners have you had in the past month?	94	.7234	.7952
7. How many times do you engage in sexual intercourse per week?	94	.8511	.9499
8. Would you say you use protection during sex?	82	1.3659	.7937
9. Only people who look sick can spread the AIDS virus?	93	1.9892	.1037
10. Condoms reduce the risk of getting the AIDS virus.	94	1.1277	.3661
11. A person can get the AIDS virus even if he or she has sexual intercourse just one time without a condom?	94	1.0745	.3663
12. Only people who have sexual intercourse with gay (homosexual) people get AIDS.	94	2.0106	.1031
13. Birth control pills protect a woman from getting the AIDS virus	94	2.0106	.1031
14. Do you think that the knowledge that you have empowers you to be more protective of your body?	94	1.0426	.2902
15. What is your parent's education levels:	94	3.2234	1.0281
Mother:	88	3.2727	.9794
Father:			

## APPENDIX D: TABLE continued

Question	N	Mean	Std. Deviation
16. What is your parents marital status?	94	1.9787	1.1262
17. While living at home would you say that your household income was:	94	3.8191	1.6195
18. Do you receive federal or state funds to aid in your college expenses?	94	1.3191	1.0897
19. I feel that I am a person of worth, at least on an equal basis with others.	93	1.0430	.2040
20. I feel that I have a number of good qualities.	94	1.0426	.3251
21. I feel that I am a failure.	94	3.9149	.3166
22. I do not have much to be proud of.	94	3.9149	.3784
23. I take a positive attitude toward myself	94	1.1809	.5280
24. On a whole I am satisfied with myself.	93	1.4624	1.1568
25. I feel powerful in all of my sexual relationships.	78	1.5641	.6363
26. I feel comfortable with discussing my sexual preferences with all of my partners.	84	1.3095	.6581



## BIBLIOGRAPHY

Ajzen, I., & Fishbein, M. (1980) Understanding attitudes and predicting social behavior. Prentice Hall Publishing. Upper Saddle River, New Jersey.

Barker, J., Battle, R., Cummings, G., & Bancroft, K. (1998) Condoms and consequences: HIV/AIDS education and African American women. Human Organization, 57, 273-283.

Braithwaite, R., Stephens, T., Taylor, S., & Braithwaite, K. (1998). Behavioral predictors of intended sexual behavior among a sample of African American undergraduates. Journal of Black Psychology, Vol (24) pgs. 164-177.

Browne J., & Minichiello V. (1994). The condom: why more people don't put it on. Sociological Health Illnesses, 16: 229-251.

Centers For Disease Control (1997) HIV/AIDS Surveillance Report. Year-end edition, cases through December, 9, 1-40.

Centers for Disease Control (1991) HIV/AIDS surveillance. Atlanta, GA

Chodorow N. (1978). The reproduction of mothering: psychoanalysis and the sociology of gender. Berkeley: University of California Press.

Chu, S., Buehler, J., & Berkelman, R. (1990). Impact of the human immunodeficiency virus epidemic on mortality in women of reproductive age, United States. Journal of the American Medical Association, 264, 225-229.

Cochran, S., & Mays, V. (1993) Applying social psychological models to predicting HIV related sexual risk behaviors among African-Americans. Journal of Black Psychology, 19, 142-154.

Cook, T.D., & Campbell, D.T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Chicago: Rand McNally

Dalton, H. (1989). AIDS in blackface. Daedalus, 118, 205-221.

DHR Office of Communications (1999). Fact sheet: teens, sexually transmitted diseases and AIDS. Georgia Department of Human Resources Division of Public Health.

Fears, D. (1998). AIDS among Black Women: Seen as a growing problem. ABC News Internet Ventures. Los Angeles, CA.

Grinstead, O., Peterson, J., Faigeleles, & B. Catania, J. (1997) Antibody Testing and Condom Use among Heterosexual African Americans at Risk for HIV Infection: The National AIDS Behavioral Surveys. American Journal of Public Health, Volume 87, No. 5.

Hammonds, E. (1987). Race, sex, AIDS: The construction of other. Radical America, 20: 28-36.

Hines, A., & Graves, K. (1998) AIDS Protection and contraception among African American, Hispanic, and White women. Health & Social Work, Volume 23(3), 186-194.

Jemmott, L.S., & Jemmott, J.B. III (1992) Increasing Condom- Use Intentions Among Sexually Active Black Adolescent Women. Nursing Research, 41, (5), 273-279.

Kalichman, S., Williams, E., Cherry, C., Belcher, L., & Nachimson, D. (1998). Sexual coercion, domestic violence, and negotiating condom use among low-income African American women. Journal of Women's Health, Vol 7, 371-378.

Land, H. (1994). AIDS and women of color. Families in society: The Journal of Contemporary Human Services, 75: 355-361.

Mays, M., & Cochran, D. (1988). Issues in the perception of AIDS risk and risk reduction activities by black and Hispanic/Latina women. American Psychological, 43, 949-957.

National Institutes of Health. (1996). Fact Sheet: Women and HIV. Office of Communications and Public Liaison.

Peterson, J., & Marin, G. (1988). Issues in the prevention of AIDS among black and Hispanic men. American Psychologist, 43, 871-877.

Poppen, P., & Reisen, C. (1994). Heterosexual behaviors and risk of exposure to HIV: Current status and prospects for change. Applied and Preventive Psychology, 3, 75-90.

Prochaska, T., Albrecht, G., Levy, J., Surgue, N., Kim, L. (1990). Determinants of self-perceived risk for AIDS. Journal of Health and Social Behavior, 31, 384-394.

Pryor, F. (1981). The "new class": analysis of the concept, the hypothesis and the idea as a research tool. American Journal of Economics and Sociology, 40: 367-380.

Reuters. (1999). Women's HIV Misdiagnosis. ABC News Internet Ventures. Los Angeles, California.

Roper, W., Peterson, H., & Curran J. (1993). Commentary: condoms and HIV/STD prevention-clarifying the message. American Journal of Public Health, 83

Seal, A., Minichiello, V., & Omodei, M. (1997) Young women's sexual risk taking behavior: re-visiting the influences of sexual self-efficacy and sexual self-esteem. Royal Society of Medicine Press Limited, Volume 8, 159-165.

Selik, M., Castro, K., & Pappaioanou, M. (1988). Racial/ethnic differences in the risk of AIDS in the United States. American Journal of Public Health, 78, 1539-1545.

Siegal, K., & Gibson, W. (1988). Barriers to the modification of sexual behavior among heterosexuals at risk for acquired immunodeficiency syndrome. New York State Journal of Medicine, 88, 6-70.

Stevens, R. (1998) Understanding HIV-AIDS and the special needs of African American Women and adolescents. Psychotherapy in Private Practice, Volume 17(3), 21-33.

Staples, G. (2000) Tackling HIV/AIDS' grip on black women. The Atlanta Journal-Constitution, Friday, September 29, 2000 A3

St. Lawrence, J., Eldridge, G. Reitman, D., Little, C., Shelby, M., & Brasfield, T. (1998) Factors influencing Condom use among African American Women; Implication for risk reduction interventions. American Journal of Community Psychology, Volume 26(1), 7-28.

Tashakkori A., & Thompson V. (1992). Predictors of intention to take precautions against AIDS among black college students. Journal of Applied Social Psychology, 22: 736-753.

Thomas, S., & Quinn, S., (1991). Public health then and now The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV Education and AIDS Risk Education Programs in the Black Community. American Journal of Public Health, Vol. 81, No. 11

Weeks, M., Grier, M., Radda, K., & McKinnley, D. (1999). AIDS and social relations of power: urban African women's discourse on the contexts of risk and prevention. Lawrence Erlbaum Associates, Inc., Mahwah, NJ.

Wheller, S.& Romney, A. (1988). Systematic Data Collection. Qualitative Research Methods Series 10., Newbury Park, Sage Publications.